Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ALLIED MEDICAL CENTERS

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-12-0035-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is the BRC order dated July 20, 2011. Parties agree to a sustainable and compensable injury on 1/4/11."

Amount in Dispute: $810.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2011 March 3, 2011 March 4, 2011 March 9, 2011 March 10, 2011 March 16, 2011 March 17, 2011 March 18, 2011	CPT Code 97110-GP (x3 units) at $168.00 and (X2 units) at $112.00	$168.00 $168.00 $112.00 $112.00 $112.00 $112.00 $112.00 $112.00	$0.00
March 2, 2011 March 3, 2011 March 4, 2011 March 9, 2011 March 10, 2011 March 16, 2011 March 17, 2011 March 18, 2011	CPT Code 97112-GP	$56.00/each	$0.00
March 2, 2011 March 3, 2011 March 4, 2011 March 9, 2011 March 16, 2011 March 17, 2011 March 18, 2011	CPT Code 97124-GP	$43.00/each	$0.00

March 9, 2011 March 10, 2011	CPT Code 97140-GP	$56.00/each	$0.00
March 17, 2011	CPT Code 99080-73	$15.00	$0.00
TOTAL		$810.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307, effective May 25, 2008 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. EOBs submitted with the requestor's dispute indicate the respondent has raised issues of Compensability, Extent, and/or Liability.

Issues

1. Has the compensability/liability/extent of injury issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   On July 20, 2011, the parties reached a Benefit Dispute Agreement that the claimant sustained a compensable injury on January 4, 2011 and that the compensable injury extends to the lumbar spine, bilateral shoulders and left knee but does not extend to the left elbow, right knee and right ankle. The Division concludes that the compensability/liability/extent of injury issue has been resolved.

2. A review of the submitted medical records finds that the disputed services were for treatment of the lumbar spine, bilateral shoulders and knees, left elbow and right ankle; therefore the treatments in dispute were rendered for an injury which the parties agreed was not compensable according to the Benefit Review Conference Agreement of July 20, 2011 as discussed above. The requestor rendered health care to this injured employee for the non-compensable right knee and ankle; therefore, no reimbursement can be recommended for the services in dispute

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		04/30/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.